A roundtable discussion on *Nursing and the economic downturn* was held on 25 August 2009 at RCN headquarters in London. An invitation-only meeting, it brought together prominent figures in nursing, together with leading external thinkers and influencers who ordinarily have relatively little direct involvement in developing nursing policy.

With over 670,000 registered nurses throughout the UK the profession has significant potential to lead and affect both health and social change and it is for this reason that the RCN sought to facilitate a conversation between nursing leaders and individuals who shaped and influenced broader social change.

On 17 March the Prime Minister announced the creation of a Commission on the Future of Nursing and Midwifery in England. The RCN has submitted five papers on each of the Commission’s work streams. However the changing economic environment is a significant factor in setting the context for the work of the Commission and the future of nursing and midwifery. The RCN hosted the roundtable discussion in order to explore these issues further and this paper, summarising the discussions, will be submitted to the Commission and will inform the work of the RCN Policy Unit in influencing health and social care policy.

The roundtable participants were:

- **John Carvel**, former Social Affairs Editor, *The Guardian* (Chair)
- **Cynthia Bower**, Chief Executive, Care Quality Commission
- **Professor James Buchan**, Queen Margaret University
- **Dr Peter Carter**, Royal College of Nursing
- **Professor Celia Davies**, Open University
- **Anna Dixon**, The King’s Fund
- **Professor Julian Le Grand**, London School of Economics
- **Dr Patrick Nolan**, Reform
- **Professor Anne Marie Rafferty**, King’s College London
- **Professor Jane Salvage**, independent health care consultant and joint lead of the support office for the PM’s Commission
- **Eileen Sills**, St Thomas’s Hospital
- **Rumbi Tarusenga**, London Rebuilding
- **Jo Webber**, NHS Confederation

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Royal College of Nursing
Nursing and the economic downturn

Setting the scene – Introduction

John Carvel and Peter Carter set the scene for the discussions highlighting the following:

- Government borrowing and worsening global economic conditions have resulted in significant public sector borrowing and a budget deficit of £175bn that the Government will have to address. The NHS Chief Executive David Nicolson has stated the need to secure substantial ‘cash releasing efficiency savings’ in the NHS budget of between £15bn and £20bn between 2011 and 2014.
- There is concern that funding cuts and the drive for efficiency savings could result in cutbacks including bed closures, cancelling new services and staffing reductions. With approximately 330,000 registered nurses employed in the NHS and a pay bill in the region of £12bn it is unrealistic to expect nursing to escape close scrutiny.
- The health sector has seen a series of high profile reports and statements on the future of public expenditure and historically there have been many experiences of nursing costs and budgets being targeted for savings during times of austerity.
- The difficulty in robustly identifying the nursing contribution, in pounds and pence, to the overall process of patient care and the soft value that society generally places on caring remains a significant challenge for the profession.
- Planning to manage the impact of this step change in funding compared to the previous years of real year on year growth is urgent and critical.
- There are two main ‘camps’ in this debate; those who suggest that, despite the need for cuts elsewhere, NHS funding should be ring-fenced and maintained, versus those who argue that cuts across all areas of public expenditure including the NHS are required.
- The current health policy focuses on quality, together with the shift in the provision of health services away from hospitals and into patients’ homes, and has the potential to create significant opportunities for nursing to be at the ‘cutting edge’ in terms of introducing new ways for care to be delivered. In addition an ageing population and the rise in those suffering from chronic and long term conditions will result in an increasing demand for nursing care.
- Balancing the supply of nurses with the demand for nursing is a key challenge for the Prime Minister’s Commission on the Future of Nursing and Midwifery to consider and make recommendations to address.
- These discussions are currently set against the backdrop of a forthcoming general election.

What does history tell us about the impact of an economic downturn on nursing and wider health care delivery?

During previous economic downturns two important trends have been looser labour markets and tighter funding. Those nurses that kept their jobs often worked increased hours and there was lower mobility between jobs. Currently these trends are again evident although nurses are also expressing interest in returning to work and delaying retirement. However, in labour market terms, unemployment lags behind recession so employment conditions may be at their most difficult years, rather than months, after the recession.

In the past training budgets have been targeted for savings. This resulted in periods of ‘boom and bust’ workforce planning with consequent knock-on effects for the educator workforce. These staff could not be replaced quickly when the cycle returned to ‘boom’.

Vacancy freezes resulted in fewer jobs for newly qualified nurses and nursing roles considered expensive, such as specialist and nurse consultants, were also often targeted for savings.

Historically public health and health prevention budgets have also been subject to cutbacks.

During previous periods of economic downturn there was a tendency for ‘counter cyclical’ patterns of spending; higher spend on the NHS when the broader economy was going through a downturn, followed by a later period of much lower spending on health than the wider economy. This pattern is being repeated with the wider economy now potentially moving towards gradual recovery but pressure being placed on NHS budgets.

The establishment of an independent Pay Review Body in 1983 has, to a degree, insulated the pay bill from the wider economic downturn.

The nature of cuts was typically experienced as short term ‘slash and burn’ with little apparent thought for the consequences on service delivery,
morale and motivation, and recruitment and retention. The tragic events at Mid Staffordshire NHS Foundation Trust serve as a powerful example of the consequences of financial short termism and the relationship between nurse staffing levels and patient safety and quality.

Is there a difference with the current economic downturn and what are the key challenges?

The focus on quality and its centrality to policy following the NHS Next Stage Review is a significant difference from previous periods of economic uncertainty. Identifying quality, innovation and prevention alongside productivity as overarching principles to inform financial decision-making has the potential to mitigate against previous approaches and for the lessons of history to be learned. In addition, increasing attention on patient experience measures has the potential to shift the focus of delivery away from just activity levels.

Changes in IT mean that there is now considerably more scope to use real time patient information to monitor and adapt service provision on a continuous basis and many providers now use more sophisticated tools to determine the number of nurses required (which relate to patient acuity). Quality accounts and care metrics/indicators are being introduced and used across organisations to monitor benchmark and drive quality improvement.

However the workload of hospitals has changed significantly, with higher levels of patient dependency and shorter length of stays that often require more experienced staff and a ‘richer’ skill mix.

The way previous periods of economic uncertainty were dealt with in the NHS (for example the 05/06 deficit crisis) has created mistrust amongst some of the workforce and messages that ‘this time it will be different’ can be met with cynicism and even resistance.

The fact that a general election has to be called in the next 8/9 months means that public sector funding will remain in the media spotlight. The ‘spin’ and potential communications overload could result in frequent policy announcements with the potential for confusion and mixed messages. An obvious solution to dealing with the funding shortfall is to raise taxation, but the highly charged pre-election political environment will rule this out and attention will focus on productivity and cost savings in the NHS.

Transforming Community Services (TCS) is a significant policy vehicle and there is a broad consensus in relation to improving the commissioning function. However, there is uncertainty about the form and impact of new provider organisations and continuing suspicion that some form of ‘marketisation/privatisation’ of health is the hidden agenda.

There have been a number of ‘false dawns’ in relation to the acute to community shift. Whilst some trusts are working hard to embrace this change some commentators have suggested that there is a danger in overpromising what can be delivered.

Those acute providers actively pursuing vertical integration and taking over PCT provider arms could exploit the opportunity to integrate services better along the full length of the care pathway bringing benefits both in terms of quality and cost savings. Equally though there are concerns that acute trusts may just asset strip, and doubts exist about how well they understand the needs of the community or provision of primary care. Examples such as the Baby P case highlighted that well-regarded acute trusts might not always be geared up for delivering services in the community.

Joint commissioning between PCTs and local authorities could be an important way forward but current payment structures and the failure to ‘unbundle’ the tariff acted as a ‘barrier’ to the shift from acute to community. In addition, the current inability to describe in a simple tangible form what a new model of care in the community actually looks like is a further block to building the momentum for change. In the absence of such information sceptics may increasingly suggest it is a ‘care on the cheap’ alternative.

There is still an unresolved tension between central and local autonomy and planning and the balance between cooperation and collaboration versus competitive pressures to drive productivity and improvement. There is still no consensus in relation to the ‘competition v managed collaboration’ conundrum.
The regulation infrastructure has changed significantly over recent years. Regulation is now much more robust, transparent and sophisticated. We have moved on from just focusing on star ratings and now know much more about ensuring quality.

The pay and pensions debate will continue during the current downturn. There is likely to be continuing attention on what some commentators have presented as a ‘feather bedded’ pension scheme for NHS staff. If the private sector ‘bounces’ back but public sector workers are subject to less favourable pension provision and either very low increases or real cuts in wages, it could create potential for unrest within the workforce which may impede change. It is also virtually inevitable that there will be some form of trade-off between public sector pay and job security.

Finally, the relationship between the higher risk of poor health and long term unemployment during recession is well known and documented. These impacts are likely to be most severely felt by the vulnerable and needy members of society which raises concerns over increased health inequalities. In many cases, losing your job can be the tipping point which leads to isolation, family breakdown and mental health problems. Simply reducing the supply of health care at a time when demand is rising will have implications for the wider fabric of society.

What opportunities exist for nursing?

The future demand for health care is more about care and support than about cure and technology. In which case a powerful argument exists to say that the nursing family, encompassing registered nurses and the health care support workers, will be leading the way in terms of care delivery.

The focus on quality is integral to the principles and ethos of the nursing profession. Nursing could develop innovative new models of care delivery and are ideally placed to co-ordinate the delivery of care closer to patients’ homes and along care pathways. There are opportunities for nurses within PCTs to be focused upon population needs, especially for long term conditions. Some good examples already existed, for example Own Health in Birmingham which includes helplines staffed by nurses.

In addition, the potential ‘reach’ of the nursing profession into communities and families means that they can lead health prevention and promotion strategies.

Many nurses are already working alongside other parts of the public sector such as local authorities and third sector organisations so, again, can lead the development of joint working. It is also an opportunity to not just think about ‘bricks and mortar’ but also focus on delivering flexible health care.

There are also opportunities to use tendering as a way of bringing in new ideas and approaches. Sharing of information is crucial and nurses need to be open to change, as well as playing their part in a system that encourages co-operation and collaboration. There is, however, also a need to have both the motivation and the leaders to drive this through despite the challenges.

Tangible models of care setting out what care in the community actually looks like need to be more clearly described and publicised. Critical issues that determine the feasibility of models of care such as patient volumes should be made explicit. For example, blood tests at polyclinics need high throughput to ensure a sufficiently low unit cost.

The nursing function is ideally placed to support and develop co-operation and collaboration between providers, including both health and local government, and to move forward in delivering the ambition of seamless care along a pathway. However both practitioners and organisations need to be explicitly incentivised in order for this to become a reality.

Nurse leadership in both provider and commissioning functions in the community is important as nursing has a significant contribution to play in assessing and planning services to meet population health needs as well as delivering services. The nursing voice in commissioning will also be an important enabler to achieving population-facing and public-involved commissioning.

Periods of economic downturn can be times of innovation for service delivery and dynamic changes in roles and skill mix. Nursing may not realise it but it is in pole position to give voice to the quality principle and lead the development of new models of care.

A challenge was raised around whether the economic downturn created a ‘burning platform’ in terms of the sustainability of the current NHS model. If it has then nursing has a choice to stay where it is and feel the heat or jump and lead the way in creating alternative models of delivery. Is it enough to simply wait to see if nursing responds or should more powerful incentives be introduced to encourage and reward nurses for leading innovation?
Nursing should position itself as the champion of quality – it should be the pre-eminent principle for the profession, over and above professional interests.

Nursing is in a leading position to take forward the development of new models of care. However, there is a lack of incentives to encourage this for both practitioners, such as nurses, and organisations.

The nursing workforce must not be cut but it must be flexible. The current workforce should be supported through training and development to take on new roles in new settings to support the acute to community shift.

The public expect the profession to deliver excellent hands-on care and provide expert and specialist advice. This is not an either/or for patients or the profession but the breadth of the nursing role needs to be acknowledged and supported.

There is a significant relationship between nurse staffing levels and quality of care. The use of ‘slash and burn’ methods for cutting posts, grade deflation and changes in the workforce skill mix remain a significant issue. Trust Boards and service commissioners should have indicators and metrics in place to assure themselves that nurse staffing levels are appropriate.

Capturing and analysing quality data on patient experiences is a key tool that can improve the delivery of care. It allows the NHS to understand and respond to the needs and wants of patients and the public.

The current community workforce is ageing faster than the population of nurses and there are insufficient numbers of district nurses, school nurses and health visitors. Current nurses should be supported to fast-track into these roles.

There is a need to recognise the links between the likely demand for ‘skilling up’ nurses for community roles and the need for educational infrastructure. Training and development budgets are crucial to facilitating this. The NHS Constitution offers an opportunity to secure training for nursing with commitments to CPD and revalidation.

The value and effectiveness of specialist nurses who support patients with long-term conditions should be promoted, particularly to senior managers. A more powerful business case for nursing in terms of ‘invest to save’ needs to be made.

Health systems regulators should have teeth. This means having sufficient powers to act swiftly when there is a risk of harm and in extreme cases, close providers down. The nursing profession is a key partner for health system regulators in protecting and promoting quality care.

Nursing leadership is critical at Board level. Nurses have the mix of knowledge and expertise in assessing the care needs of patients as well as having the skills in designing and delivering care packages to meet that need. Nurses at board level also have a critical role in reinforcing the importance of quality to all aspects of the organisation.

Decisions about pay and pensions affordability must be balanced with recruitment and retention, morale and motivation and quality considerations.

Maintaining workforce morale and commitment to reform will be a significant challenge for politicians, policy makers and NHS leaders over the coming months.

The economic downturn presents many threats therefore it is critical that the nursing profession proactively identifies and exploits the opportunities that also exist.